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**ANNUAL REPORT  
OF  
CEHAT**

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**2011-2012**

## **I. RESEARCH**

### **Maharashtra Human Development Report (2012)**

The team from CEHAT prepared a background paper on health which was accepted by YASHADA for the Human Development Report on Health after peer review. The background paper explored health disparities within the state and between districts. It found that the level of inequalities persistent within Maharashtra is unacceptably high. Most public as well as private hospitals are in the cities and in 1991 urban areas had 8 times more hospitals and 13 times more beds than rural areas. However, in 2005 this disparity worsened to 13 times more hospitals and 19 times more beds. In Maharashtra, only 37.5% villages have a Sub-Centre, only 11.4% villages have a PHC, only 42.6% Villages have a health facility, and only 38.9% Villages have a doctor. Data from health programmes indicate that Malaria and TB are emerging as two major threats- Malarial deaths have quadrupled over the last ten years, and urban TB, mostly drug resistant, is on the rise. Nutritional indicators from the state do not paint a promising picture either. In a way this is a reflection of low budgetary priority given to health and nutrition. When taken as the proportion of GDP, Maharashtra is one of the lowest public health spenders in the country at 0.5%. In Maharashtra, variation in infant mortality between districts seem to be associated with the districts economic development. While the central government is giving more budgetary resources to the state, the state government is not reciprocating to the extent necessary, but abdicating its role of contributing more. State Budgets need to be augmented substantially to fully realise health outcomes. For this the state health sector budget needs to be increased substantially. The paper also draws attention to the fact that Maharashtra has one of the largest private health sectors in the country, with which the state is forging partnerships in the form of PPPs. Yet, there is no regulation of the sector. Further, Charitable hospitals who are expected to provide services to the poor too are not doing so. The paper calls for the government to take regulatory action in this regard.

The HDR chapter that deals with health has been finalized and the report will be printed this year (2012). It is hoped that the publication will reorient the health policy in particular and social sector policy in general of the state towards better equity.

### **Charitable Trust Hospitals Study**

Mumbai is a city where partnerships between the public and the private sector have existed in the health sector for a long time, in the form of contracting in facilities. In view of the large concessions and subsidies given to private hospitals run by "State Aided Public Trusts", and in order to formalise already existing loose arrangements, the Bombay Public Trusts (BPT) Act, 1950 in its Section 41AA mandated the Charitable Trust Hospitals to earmark 20 per cent of their operational beds for free and concessional treatment of the poor. Over the last few decades, the nature of Charitable hospitals have undergone tremendous change. Many such hospitals have allied with the private sector and in some cases global healthcare chains. In such a

situation, the exclusive purpose of "medical relief" has come under attack, and there has been understandable reluctance on part of the hospital managements to comply with the conditions that earmarked beds for treatment of the poor.

In 2004, a Public Interest Litigation was filed in the High Court of Mumbai, challenging the hospitals that were not providing free treatment to poor and weaker sections. A scheme was instituted by the high court formalising the 20 per cent beds set aside for free and concessional treatment. The ongoing study uses the data being submitted by hospitals to the charity commissioner's office to assess the level of compliance. The study also tries to find the geographical distribution of these free beds in Mumbai and prepare a typology of charitable hospitals in Mumbai. We hope that the findings of the study would be useful in making key recommendations for effective implementation of the high court scheme, especially for guaranteeing access to the poor to the 20% beds that are set aside.

### **Study on Rashtriya Swasthya Bima Yojana**

RSBY is a health insurance programme which intends to provide health assistance to people living Below Poverty line, with the technical assistance of agencies like the World Bank and GTZ. The beneficiaries are families of workers in the unorganized sector. The scheme provides cashless hospitalization benefit up to Rs 30000/- for most of the diseases that require hospitalization, in specified empanelled hospitals for a family of five members (with no age limit). As an insurance scheme for the poor based on the PPP model, it is hoped that the scheme will eventually make the geographical distribution of health care facilities more equitable vis-à-vis the rural-urban divide. It is visualized that the scope for making profits will make the private sector set up hospitals even in the interior rural areas. Enrolment of beneficiaries as well as empanelment of public and private hospitals is underway. Till date, of the identified 51373696 Below Poverty Line (BPL) families, 21146656 have been enrolled. All BPL families are expected to be covered by 2012. Likewise, across 388 districts of 29 states and union territories, 6148 private hospitals and 2538 public hospitals have been empanelled by various insurance companies taking part in the scheme. 2,354,959 hospitalization cases have been reported across the country, as per the RSBY data management system.

Literature survey indicates that data on utilisation of services according to gender, age, location, type of insurance etc present patterns that need to be looked at closely at a more disaggregated level. Interestingly, the need to have private providers as a unit of analysis has not been addressed by existing studies on RSBY. While most of the studies identify cost-escalation as a great if not the greatest challenge to RSBY's future, this is one aspect that needs to be explored. The proposed study plans to conduct a review of the scheme which would, at least partially, address these issues. Comparing three states (Kerala, Maharashtra and Chhattisgarh) selected according to different degrees of participation of private providers and comparing utilization, rejection ratios, etc across categories like gender, age, location, type of insurance etc will throw up interesting insights into the working of the scheme, yet

unexplored. It is hoped that the outputs of the study will provide evidence that will help the scheme to adapt over time, as is its stated principle.

### **Health of Muslims in Maharashtra**

This project is an attempt to understand the health status of Muslims in Maharashtra, through review of existing studies and analysis of secondary data sources. It seeks to understand the health status of Muslims in terms of morbidity reported by them, utilization of health facilities and cost of health care. Muslims comprise about 10% of Maharashtra's population and approximately 70% of them reside in urban areas. Within these urban areas, the feeling of extreme insecurity due to growing communalism has resulted in the exodus of Muslims from mixed communities into homogenous ghettos. The studies conducted by the minorities commission show that living conditions in the ghettos are abominable, leading to several communicable diseases. The areas seem to be neglected by the municipal corporations - access to clean drinking water and sanitation is extremely poor. There is a dearth of public health facilities in some ghettos such as Mumbra and Bhiwandi. Where available, the quality of public health facilities is poor and so people prefer to access private health care. However, as the population is largely economically deprived, they cannot afford to access private health care and there is no option but to utilize poor quality public facilities. On the whole in Maharashtra, Muslims fare better than other groups in terms of child mortality rates, but this is because they are largely concentrated in urban areas. Within urban areas, however, they do not fare as well and the IMR is actually higher than other groups. Similarly, most deliveries take place in institutions because of the urban location, but it is important to note that home deliveries among Muslims do occur even in urban areas. The paper also discusses the behaviour of health professionals in public health facilities that reflect communal stereotypes and biases.

It is hoped that the findings of this paper will provide direction to the Government of Maharashtra's efforts in addressing the needs of this minority population.

### **Using the Public Expenditure Tracking Survey (PETS) for diagnostic purpose in Health Sector in Maharashtra**

The study diagnoses institutional structures and administrative processes pertaining to the budgetary processes in health. This involves determining how the public hierarchy is structured, the roles and responsibilities of various administrative units, the processes of budget planning and implementation, the allocation rules used at the various levels, and the nature of information flows including accounting, reporting and monitoring procedures etc. The study used tracking survey of the frontline service provider and Programmes whose are specifically placed under the Directorate of Health Services (DHS), Government of Maharashtra, such as budget head which includes both curative and preventive care i.e., hospitals ( District hospital, sub-district and rural hospital) and primary health care ( PHC) under the ZillaParishad.

Through semi structured primary data was collected through interview in two districts of Maharashtra.

During the reporting period, fieldwork- primary data collection for the study was conducted in two districts in a phase manner. First phase of data was collected in the month of February-march and May-June 2011, for PHCs, Hospitals, health and other officials of district and below . The remaining data was collected from the two regional health officials and various officials at different level of hierarchy of planning department, Finance,health department after completing the district fieldwork, in the month of August - November 2011. The data collected from the interviews were translated and transcribed followed by manually coding under broad themes using MS word. After the data had been arranged into different relevant themes, analysis of broader institutional and administrative structure guiding the health sector in the state was prepared. This section specifically brings out the context in which the study is placed under the larger head of health budget processes was shared with the IBP,TA for their comments.

During the reporting period, Cehat IBP team held two separate meetings, one with advocacy TA Amitabh Behar and the other with research TA Aaron Katz to discuss issues identified from the study and plan for the extension phase. The field experiences and the findings of the study were discussed with the mentors and experts from IBP which eventually helped to zero-down on the advocacy areas. Advocacy activities have been planned on specific findings emerging from the study. Advocacy outputs in the form of notes/pamphlets/flowcharts have been planned. A summary report in Marathi has also been planned along with two regional level capacity building workshops and engagement with different official for changes.

### **Intervention research on Sexual assault**

CEHAT has been providing crisis intervention services to survivors of sexual assault and training to doctors and nurses at three public hospitals in Mumbai, since 2008. So far, over 100 survivors have been attended to at these hospitals. Data from the case records has been entered into an MIS and analysed to understand the profile of survivors, nature of assault, pathways of reporting to the health facility, factors leading to loss of evidence, relevant examination findings, health consequences of the assault. This is the only evidence of its kind available in India vis-a-vis sexual assault. A report documenting the setting up of the comprehensive health care response has been written up. The data show that a large majority of survivors of sexual assault reporting to the hospital are children below the age of 12 years. The assailant in most cases was a known person, usually a trusted person such as the child's own father, uncle, or neighbour. Often children were lured with promise of chocolates, toys, money or just an offer to play, suggesting that the act was planned and not impulsive as is often understood. It is important to note that a range of different types of assaults was noted - less than half of the cases (45%) reported with completed peno-vaginal penetration (rape). Other forms include fingering, masturbation, attempted penetration, anal penetration, touching of chest etc. Physical force was seen to be

used more commonly among adolescents and adults, rather than children and consequently bodily injuries too were seen more often in these age groups. With regard to medical evidence of sexual assault, it is important to note that only 18 of the 94 (19%) survivors reported bodily/physical injuries and only 36 of the 94 (38%) survivors presented genital injuries. A greater proportion of children (29 out of 51) presented with genital injuries. In contrast, only 5 out of 12 adolescents and 2 out of 16 adults sustained genital injuries. 61.8% of survivors had changed clothes, 50% had bathed, 36.8% had douched, 88.2% had urinated and 52.9% defecated. In these cases, even if the survivor had reached the hospital within 24 hours, the chances of finding evidence may have reduced drastically. These findings call for a re-assessment of how medical evidence is interpreted by the judicial system.

An interesting finding that emerged was that in a large percentage of cases, a health complaint resulting from the assault - such as pain in the abdomen, burning micturation, etc, - prompted disclosure. Almost half of the survivors reported to the hospital directly for treatment while the rest of them went first to the police to file a complaint. This underscores the need to recognize voluntary reporting to the health facility, as well as treatment for health consequences. 61 of the 94 survivors reported with some physical health consequence including injuries, infections, unwanted pregnancies. Some had even gone to other hospitals where evidence was collected but no treatment provided. These findings underscore the need to emphasize the role of the health system in providing treatment and psychosocial support to survivors reporting sexual assault. The study shows that with the implementation of the comprehensive health care response at these hospitals, the various components of the health system's role have been operationalised. Specific informed consent has been sought for various procedures, history documentation is thorough, examination focuses on findings related to the assault (rather than recording irrelevant information such as size of the introitus or old tears of the hymen), evidence collection is informed by history, a reasoned medical opinion, based on history and examination findings formulated for each case, copies of documentation are provided to the survivor and every survivor receives complete medical treatment and psychosocial support from a social worker.

The findings from this intervention research project will be crucial in advocating for such health system models for response to sexual assault, to be adopted by other health facilities as well. It also points to the need for developing standard operating procedures for health systems as well as other agencies such as law enforcement.

### **Management Information System for Dilaasa**

In order to enable easy, periodic analysis of cases being handled at Dilaasa Mumbai as well as other replication sites, a management information system has been developed. This MIS records information about the socio-demographic profile of women visiting the department, the nature of violence faced by them, health consequences and the nature of intervention provided by Dilaasa. In the reporting year, data from the Dilaasa Indore crisis center in MY Hospital was analysed and was

included in the report on 'Establishing Dilaasa Indore'. This report documented the entire process of establishment of the crisis center in Dilaasa, challenges faced in setting it up and sustaining it. In the reporting year, case records from 2007 to 2011 have been entered in the MIS. The data is currently being cleaned and will be analysed over the next six months. Research papers on specific themes have been planned, such as looking at pathways through which women access the crisis center, the health system's role in early identification of domestic abuse among women, violence faced by women during pregnancy and women attempting suicide.

### **Violence against women health workers**

The health system has a large number of women employees working in various capacities including nurses, doctors and ayabais. There is evidence from other countries as well as anecdotal evidence that nurses face abuse in the workplace because of their disadvantaged position as well as the nature of their work. As with any other sector, the Vishakha Guidelines on addressing sexual harassment at the workplace are applicable to health facilities as well, and it is imperative for health administrations to understand and address the abuse faced by women working in their facilities. This study was undertaken with the objective of mapping the different kinds of abuse faced by women health workers within the hospital as well as in their personal lives, to understand the avenues accessed by them to address this abuse, and the barriers faced therein. Focus Group Discussions were held with women workers at different levels including doctors, sister-in-charges, staff nurses, ayabais and maitranis. The findings from the study have been published in the book "In Sexual harassment at workplace" edited by Deepti Deshpande and Nikhil Bhagwat. Nashik: Home Science Faculty of Gokhale Education Society's SMRK-BK-AK-Mahila Mahavidyalaya.

Various types of abuse, particularly sexual abuse were reported by all categories of health workers. Abuse by senior doctors and peers included passing lewd remarks, making sexist jokes, coming drunk to work, asking personal questions about childbirth and sexuality, passing comments on appearance. Nurses reported that labour staff often refused to follow instructions from a woman and would come to the workplace drunk. All categories of health workers also reported facing abuse from patients. They stated that patients would stare at them, undress in front of them to embarrass them, refuse to accept advice from female doctors etc. With regard to reactions and perceptions about the violence faced, the study found that women health workers perceived the violence to be a result of unequal status of men and women within the health system. No matter how educated they were, they felt like they were treated as objects and men wanted to be at the top of the hierarchy. There was also a fear among the respondents that if they complained about the behaviour they would be labelled as intolerant or their evaluation would suffer. So they felt that it was more appropriate to ignore the abuse. Often they did not speak to anyone about the abuse at all. While nurses were reluctant to make use of formal redress mechanisms, they did state that they discussed the abuse with colleagues. Among doctors however,

there was no such forum. They were completely unaware of sexual harassment committees that are established in the hospitals.

The study points to the need to for greater awareness among both men and women health workers on forms of sexual violence and women's rights in this regard. Redress mechanisms must be made more responsive and swift.

#### **Development of ethical guidelines for domestic violence counselling:**

While several counselling centres are functioning in India and providing services to survivors of domestic violence, there has been no endeavour to evolve guidelines for counselling in DV. After the publication of counselling ethics case book, CEHAT felt the need to take a step forward from the ethics casebook, and began the process of developing ethical guidelines in domestic violence counselling. The aim of these guidelines was to cultivate good practice in domestic violence counselling and educate counsellors on the discourse in counselling ethics. CEHAT invited experts from the field of psychology, social sciences, counsellors, psychiatry and ethicist and formed a committee. The committee consists of : Amar Jesani, Anuradha Kapoor, Jaya Sagade, Manisha Gupte, Prabha Nagaraja, Soumitra Pathare, U. Vindhya, A draft of the ethical guidelines was prepared based on the review of International codes of ethics and our experience of domestic violence counselling at the crisis centre. The guidelines presented the principles and values of feminist counselling and steps in applying the ethics frame work while counselling. In its first meeting held on 24<sup>th</sup> May 2011, the guidelines, its purpose, objectives and content was discussed threadbare. The committee gave detailed feedback on the draft guidelines. They were revised substantially and presented to the committee again on 4<sup>th</sup> November 2011. At the meeting there was a debate on whether these should be termed as 'guidelines' or they should be termed 'ethical standards', but it was concluded that as India doesn't have a regulatory body for counselling per se, and adherence to 'standards' cannot be enforced, they should be called 'guidelines'. Individual practitioners and organizations practicing DV counseling need to embrace such guidelines in order to ensure good Feedback was also received on the structure of the guidelines which are currently being revised. The final consultation for finalizing them would be held in June 2012.

#### **Evolving 'good practice' for responding to attempted suicide at the hospital**

Dilaasa's experience has demonstrated that there is a close correlation between attempted suicide and domestic abuse. Several women are admitted to the hospital every month reporting 'accidental consumption of poison', which is actually an attempt to end their lives. Screening of such patients by counsellors has often identified abuse as an underlying trigger for attempting suicide. Based on this experience, Dilaasa evolved a counselling strategy to these clients. This counselling strategy is operational in 2 hospitals in Mumbai where Dilaasa is located. A study was undertaken to understand the existing psychiatric models of response to attempted suicide at other public hospitals in Mumbai. The study was conducted in collaboration

with the department of Psychiatry at KEM hospital, to understand the psychiatric response to attempted suicides amongst women facing domestic violence. Interviews were conducted with Associate professors, resident medical officers and heads of the department from JJ, KEM and Rajawadi psychiatry departments on the response of their respective departments to women attempting suicide. The interviews with the psychiatrists clearly brought out that most psychiatrists identify that women attempting to end their lives are facing abuse in their families. However their psychiatric training made them label such women as 'impulsive', 'malingering' and 'attention seeking' without making any connection to the social factors that allow abuse against women. The focus in the diagnosis was always on the woman's capacity to cope or not cope, but never on her stressful and abusive living environment. Most psychiatrists identified that women require counselling services, but felt that it is beyond the role of a psychiatrist to do so.

These findings are to be shared with a consultative group of senior psychiatrists, psychologists and social workers, working on the issue of violence and mental health. The aim of the consultation would be to develop a uniform protocol for responding to attempted suicides amongst women facing abuse. The consultation is due to be held in end of April 2012.

### **Study on response of hospitals to Terror Attacks**

After the terror attacks of 26/11/08 in Mumbai, we had proposed a study to document how public hospitals responded to these situations as they are the ones that are expected to bear the burden of care towards survivors of mass violence. The study is being conducted in collaboration with the Center for Disaster Management, Tata Institute of Social Sciences. Interviews were conducted with 54 health care providers across the 4 hospitals that responded to the attacks. In this year, the data obtained as part of the study was analysed. Preliminary findings suggest that the response to the attacks did not follow any pre-determined plan. There was no clear definition of roles and providers acted based on their experience. There was little or no awareness of about existence of a disaster management plan, or each providers' role in it. This was true both of hospitals who received victims of the attacks, as well as the hospital that itself was attacked. The preliminary analysis of data has been completed and findings of the study are ready. They were presented to the PDC as well as to consultants at the Center for Disaster Management, TISS. Report writing is under way. The findings of the study will be shared with the concerned hospitals and the health department. We hope that learnings from this study will contribute to strengthening the response of health systems during emergencies such as these.

## **II. ADVOCACY**

### **Budget Advocacy:**

Alliances with the local budget partners, KHOJ and Astitva Sanstha, from Amravati and Solapur districts was developed and strengthened. The partners in both the districts were involved in the research and accompanied researchers for primary data collection and acquiring local budgets. During this process they were able to familiarize themselves with the different offices and the relevant budget documents which can be useful in future to build evidence around the issues/problem identified in these constituencies. Further, a one day orientation workshop was organized on 24 Sept. 2011 at the end of the field work wherein fieldwork observations were shared with the organizations. Around 11 members participated from the two partnering organization. The workshop was facilitated by three officials holding senior position from treasury, finance department and health department. Apart from sharing experiences, the partners were trained in applying the budget in their activities as well as advocating for changes in allocation in their respective constituencies.

### **Providing Support to a PIL lodged in the Mumbai High Court by KHOJ**

CEHAT has continued its support to KHOJ, the petitioner of the PIL (IN THE HIGH COURT OF JUDICATURE AT BOMBAY CIVIL APPELLATE JURISDICTION WRIT PETITION NO.3278 OF 2010), on the issue of malnutrition, child death and livelihood opportunities in the tribal block of Amarati. During the reporting period there were 3 hearings wherein, it was brought to the notice of court about the huge under-utilization of the budget in the tribal department specifically in the ITDP project in Melghat blocks. The vacant sanctioned post of the nodal officer for the tribal block was brought to the attention of the court as well. The court in its order directed the State to appoint nodal officers to coordinate the activities of 6-7 department for the addressing the issues of malnutrition and child deaths. There were also issues related to inefficient functioning of the Public Distribution System.

### **Concerns raised about user fees in public hospitals**

User fee was introduced in India in the 1990s as part of Health Sector Reforms and many studies, including NSSO data show that levying user fee in public health facilities is an important factor that has contributed to the decrease in the utilisation of public health facilities over the last two decades. The broad objective of this study is to map the flow of user fee from collection, deposition, and expenditure of the funds generated by levying user fee in the Municipal hospitals of Mumbai, and understand the process of exemption from user fee and provision of Poor Box Funds to the needy. The study found that a large majority of the poor patients do not access the waivers that are meant for them. The study also found that the decisions regarding user fees are taken arbitrarily, the costs of administration are very high, and long delays are involved in patients accessing care when payment becomes a constraint to access.

The final report was published and a dissemination workshop was organised at Mumbai University on September 7th 2011, where a research brief, based on the study results was presented. The workshop saw participation from civil society activists across Maharashtra involved in work on access rights, researchers, officials as well as people's representatives. The concerns raised in the report have been part of the media advocacy, whereby journalists interested in stories related to health equity and access were engaged and given inputs for their stories. The Report of the User Fee study, the press note and the policy brief that was prepared got prominent coverage in the press. CEHAT is part of the JSA campaign against privatization of public hospitals. CEHAT is invited to present two papers in the National seminar titled "User Charges, Public Health Facilities and Universal Access" organized by Centre for Women's Development Studies (CWDS) and JNU in New Delhi later in 2012.

### **Right to health care for survivors of sexual assault: Public interest litigation**

The intervention filed by CEHAT in the PIL in Nagpur High Court, with the aim of ensuring comprehensive and sensitive provision of health care to survivors of sexual assault, continued for the second year. Revised proformas and guidelines for medical examination and treatment of sexual assault survivors were submitted to the court on 7<sup>th</sup> June 2011. In spite of such close engagement by CEHAT with the committee, the proforma submitted are not as per the standards set by the WHO. Unfortunately the petitioners did not register any objections to these proformas and therefore the court came to the conclusion that the proformas be circulated for implementation all over Maharashtra hospitals and police stations. Disturbingly, the proformas lay emphasis on injuries per se whether in penetrative sexual assault or non penetrative sexual assault. This would provide absolutely wrong directions to a doctor while conducting examinations; thereby it would be interpreted as "no injuries would mean no sexual assault". Analysis of sexual assault cases handled by CEHAT and responded to at the three hospitals implementing the comprehensive health care response to sexual assault dispels the myths around injuries completely. Further the guidelines don't even mention the nature of therapeutic care required by survivors of sexual assault. CEHAT, in response to the court order, filed a review application to draw attention of the judiciary to the fact that the proformas submitted by the committee do not follow the WHO standards and are also in contradiction with the Indian law. Several efforts were taken to build opinion amongst health professionals, NGOs and civil society on the problems with the state proforma, in the form of consultations. Since the proformas were not on par with the international standards established by the WHO for health care response, CEHAT sought a WHO technical opinion on these proformas and manual and submitted it to the GoM. Efforts were made to involve experts from the field of Medicine, women's rights activists, lawyers, social workers to discuss ways of getting the GoM to understand the problems. A state level consultation was organized at the DHS office on 6 August 2011. Simultaneously a response was filed in Nagpur court citing opinions from Indian experts, civil society, and CEHAT's data on Sexual assault as well as the WHO technical opinion. Despite the agreements arrived upon during the 6 August meeting, the revised proforma and manual submitted to the court prior to the October hearing were unacceptable on the

same grounds. Further, unscientific reasons were provided for not incorporating the changes. Petitioners also filed an affidavit levying baseless allegations against CEHAT.

CEHAT filed a response to GoM and petitioner affidavits pointing out gaps in the GOM manual and refuting baseless allegations made by the petitioners. The division bench of judges heard the matter and asked that the GOM to call a meeting with the Intervenor and Petitioners to discuss these differences and arrive at an agreeable proforma for examination and treatment of survivors. The meeting was held in the month of November 2011. However until April 2012, no revised proformas have been received from the government.

### **Abortion and sex-selection**

This year saw a series of knee jerk reactions by the GoM as a response to the rising pressure to curb sex selection. The Census 2011 found that the sex ratios have further declined both nationally as well as at the state level. In Maharashtra, the sex ratios have declined in almost all districts making it a state issue and not a regional matter anymore. CEHAT staff has been involved in many ways in responding to these proposals from writing letters to the officials, issuing press statements, working with journalists, amongst others. From proposing that abortion should be considered as murder, to replicating a bizarre scheme like 'Silent Observer' that tracks all pregnancies through software in the ultrasound machines, to seeking permissions for every abortion from municipal commissioner of the city are some examples of such responses. A lot of effort and time was spent by the CEHAT in coordination with the media, civil society representatives to ensure that a strong resistance was built. In September 2011, a committee for 'control of unauthorized abortions' was appointed under the chairmanship of Dr. Sanjay Oak (Dean, KEMH), by the Health Minister. Padma Deosthali from CEHAT was appointed on the committee along with several others including a representative of FOGSI and UNFPA. While most of the recommendations were positive - about increasing awareness of and access to abortion services - there were voices that felt that in the context of falling sex ratios, there should be more stringent monitoring of abortions. Two recommendations were made by the committee in this light - one to preserve photographic evidence of every second-trimester abortus, and the second to make medical abortion pills available only with service providers registered under MTP. Six out of the nine members vehemently opposed these recommendations arguing that it would reduce access to abortion but the Chairperson insisted on making it a recommendation along with dissenting note. A letter signed by all the six members was submitted to the health minister expressing concern over these suggestions. The latest proposal by the GoM is to designate senior police officers as nodal officers at district level for implementation of the MTP and PCPNDT Acts. Both the laws have absolutely no role for the police, the monitoring mechanisms under both the acts are clearly defined. CEHAT staff participated as resource persons for training of the police on these acts and deliberated upon the salient features of the act and emphasized issues such as confidentiality of MTP records, right to abortion for women, barriers in seeking safe

abortion, reasons for delay in seeking abortions indicating vulnerability of women. The need for privacy and confidentiality as core to abortion services was underscored.

***Asia Regional Focal Point of the IFHHRO (International Federation of health and human rights organisations)***

***Campaign against Forced and Coerced Sterilization and Denial of Access to Pain Relief***

As the Asia Regional Focal Point of the IFHHRO, CEHAT has been actively participating in all its activities. IFHHRO, OSI and other NGOs have launched a campaign in 2010 to address certain key issues of human rights violations in health care settings. One of the issues being addressed through the campaign is that of forced and coerced sterilization. In the context of India, it was felt that there is a need to deliberate upon the existing guidelines for sterilizations, particularly to address issues of quality of care and consent. A working group for evaluation of existing guidelines on sterilization was constituted, comprising of gynaecologists, representatives of professional associations (FOGSI), and policy groups working on the issue of family planning in India. Dr. Nikhil Datar (R.N.Cooper Hospital and FOGSI), Dr. Abhijit Das (Center for Health and Social Justice), Dr. Surekha Mehta (Ex-Quality Assurance Committee Convener, MCGM), Dr. Suchitra Dalvie (CommonHealth), Dr. P.K. Shah (President, FOGSI), Dr. M.C. Patel (Medico-legal Cell, FOGSI), Dr. Subha Sri (RUWSEC) were invited to be members of the working group in addition to three CEHAT representatives.

The working group met in August 2011 and discussed the existing policies and problems with the guidelines for sterilization. Prior to the meeting, CEHAT analyzed the various circulars on sterilization received from the State government, against national as well as international guidelines such as the FIGO ones. Under the national population program, there is a clear emphasis on female sterilization as a method of contraception, as against other reversible methods or even male sterilization. This raises several issues regarding women's contraceptive choices and the potential for coercion. Analysis of circulars also found that there are discrepancies between the circulars issued by the State, the National guidelines on sterilization, and those of FIGO. Based on this analysis, several issues related to informed consent, case selection, sterilization concurrent with abortion, standards of care, functioning of quality assurance committees and the need for review of guidelines for sterilization were discussed at length in the first meeting. As a first step it was discussed that the FIGO guidelines which addressed some of these issues in a progressive manner should be modified to bring in the Indian context and presented to the FOGSI for endorsement as a policy statement. The FIGO guidelines were reviewed and amendments made, contextual to the Indian scenario. The statement was sent to FOGSI for endorsement. It was reviewed by the FOGSI managing committee and revisions suggested. It has now been resubmitted to them for the next meeting to be held in September 2012.

### **III. EDUCATION AND TRAINING**

#### **Course on Health and Human Rights:**

The 9th International Post Graduate Certificate course in Health and Human Rights was organised from 23rd Jan to 1st Feb, 2012, at the University of Mumbai. Like previous years this year also the course attracted a large number of professionals and researchers from various parts of India and abroad. The intensive course covered various aspects of human rights and its linkage with health, providing participants in depth knowledge about the various concepts and their practical applications.

Advocate Mihir Desai was the Chief Guest for the Inaugural session. Advocate Desai stressed the need and importance of human rights and how health is an integral part of the entire human rights discourse. He briefly spoke about the history of human rights, UDHR and various conventions. He laid special emphasis on the human rights violations of the vulnerable groups and also spoke about various landmark judgments that have shaped the course of various laws and legislature in the country. He also emphasised the need for such courses and how they develop various skills of the participants.

The faculty for the course was internationally known professionals with vast experience in their respective fields. The methodology for the course was participatory and was highly appreciated by the participants. Apart from various sessions on different topics there was also a field visit to a one stop crisis centre, Dilaasa. It is one of its kind in India which is situated in a public hospital and provides medical, legal and psychological help to victims of violence (women). The field trip was very well received by the participants and many felt that they could do something similar in and around their work place.

#### **Course on Feminist Counselling:**

Feminist counselling as a technique for responding to survivors of domestic violence and sexual violence although found to be effective remains out of the purview of mainstream mental health practice. Therefore, a course on responding to violence against women through Feminist Counselling was developed and run by CEHAT in collaboration with TISS for the first time in April 2011. It was attended by practising clinical psychologists, social workers and educators from all over the country. Adv. Flavia Agnes was invited for the valedictory programme and she gave an inspiring talk. The 2nd course, held in November 2011, was modified based on the feedback from the participants, faculty and course coordinators. 19 participants were enrolled in the 5-day course starting 25th - 29th November 2011 in collaboration with TISS. The course threw up challenges vis a vis engagement with professionals belonging to the discipline of psychology, as it challenged the value-neutral aspects of mainstream psychology and urged the participants to place the onus of abuse on the social

environment rather than intra-psychic features of individual women. The overwhelming majority of participants did see the need for such a course in the graduate and post graduate psychology as well as social work schools.

We are now attempting to see ways and means by which TISS, our collaborative partner can incorporate the 5 day course content into their curriculum. We also aim to write a paper based on the execution of feminist counselling course.

### **Training on sexual violence:**

#### *Hospital based trainings-*

CEHAT is engaged in implementing a comprehensive health care response to sexual assault since April 2008. Regular trainings are a key component of our engagement with the 3 hospitals (Rajawadi Hospital, Oshiwara Maternity Home, Bandra Bhabha Hospital) implementing the comprehensive response to sexual assault. Every six months new resident medical officers get posted in the hospitals while the trained ones get posted elsewhere, therefore trainings are critical to induct new health care providers into the components of the sexual assault response. These trainings comprise of understanding forms of sexual violence, health consequences of the same on women and children as well as their role in responding to them. Emphasis is laid on therapeutic role of the HCP's as often their focus is restricted to medico legal evidence collection only.

In the year 2011-12, 5 trainings were conducted at the three hospitals - Rajawadi, Oshiwara Maternity Home and Bandra Bhabha hospital. 63 health care providers were trained in these. An additional joint training was conducted by Dr Shoiba Saldanah who has set up an organisation called Enfold in Bangalore, to deal with the issue of child sexual abuse. The training was aimed at providing health care providers with information and communication skills to dialogue with child survivors of sexual abuse. 26 Health care providers participated in this training program, including lecturers, medical officers, resident medical officers, house officers, and nurses.

### **National Course on Comprehensive Health Sector Response to Sexual Assault-**

In the past year, CEHAT has held two 2-day courses on "Comprehensive Healthcare Response to Survivors of Sexual Assault." The first course, organized in collaboration with Safdarjung Hospital and Sama, was held in Delhi on 1<sup>st</sup> and 2<sup>nd</sup> October, 2011. It was attended by 35 participants selected from Delhi and other parts of India. Participants included heads of department, senior specialists, and residents from gynecology and forensic medicine; nurses, lawyers, health administrators, psychologists and social workers. The second, organized in Mumbai in March 2012, was held in collaboration with the Department of Forensic Medicine and Toxicology, Seth GS Medical College and KEM Hospital. The course received an exceptional response from doctors across Maharashtra. Teams comprising of a gynecologist, forensic

medicine specialist, pediatrician and psychiatrist from medical colleges across Maharashtra as well as senior health administrators from other states of India participated, with a total of 27 participants.

The goal of these courses has been to equip healthcare professionals with perspectives and skills to adopt a comprehensive and sensitive approach in responding to sexual assault survivors. They focused on building perspectives and skills amongst healthcare providers on sexual violence, therapeutic role of doctors, dealing with ethical obligations and legal responsibilities, and deposition in court as medical experts. Experts in the fields of gynecology, forensic medicine, law and women's health served as faculty. Through hands-on methods such as role play, live demonstration, case studies and facilitated discussions, participants were equipped with skills for responding to sexual assault. At the culmination of the course, participants shared feeling more equipped in medical examination of sexual assault as well as having developed a richer understanding of legal aspects pertaining to sexual assault. It is expected that after this training delegates will devise and implement uniform, gender-sensitive protocols for sexual assault survivors in their respective health system.

Both the courses received CME accreditation from the Maharashtra and Delhi Medical Councils respectively, demonstrating their relevance to in-service training for post-graduate doctors as well as for incorporation into the medical curriculum for undergraduates.

### **Training of Health Professionals in New Delhi**

Following the 1st National Course on 'Comprehensive Healthcare Response to Sexual Assault Survivors', participants from Dadadev Hospital, Delhi were enthusiastic to implement the SAFE Kit protocol at their hospital and requested CEHAT to provide technical support and guidance.

Following the Delhi High Court Order of 2009, the All India Institute of Medical Sciences [AIIMS] in Delhi is in the process of implementing a similar sexual assault response model in their hospital. They had approached CEHAT to conduct trainings for resident doctors to equip them with necessary perspectives and skills in responding to survivors of sexual assault. Two half-day workshops were planned on the 26th and 27th of May, 2012 for doctors from the gynecology and forensic medicine departments at AIIMS and Dadadev Hospital. The workshop was attended by 100 doctors and nurses from the departments of Gynaecology, Forensics, Emergency Medicine and Hospital Management. AIIMS is currently in the process of developing a protocol for medical examination in cases of sexual assault and in this light, the proforma for medical examination developed by CEHAT was discussed at length during the training. Possibilities of a follow up training were discussed.

CEHAT collaborated with SAMA to establish a model akin to the one in Mumbai on responding to sexual assault. Such an initiative was undertaken in response to a Delhi

high court order of April 2009 directing health department, home department as well as institutions to develop guidelines to respond to sexual assault against women. We seized this opportunity to present the sexual assault response model of Mumbai and conducted trainings of health professionals from Safdarjung hospital on how health professionals should respond to sexual assault. We conducted two such trainings. In the course of our work in the hospital, the DG office issued a protocol for examination of sexual assault. However this protocol was completely regressive as it overly relied on evidence such as signs of force, built of the woman, status of the hymen and the 2 finger test. These methods have been considered redundant and have been abolished in most parts of the world. WHO guidelines have not been followed at all. This prompted CEHAT and SAMA to dialogue with the central health office in New Delhi and put on record concerns vis a vis the protocols. After much engagement with the DG office, they withdrew this protocol and deleted the 2 finger test. Yet many regressive aspects of the protocol continue. We are currently engaged in a dialogue with the central health department to replace their protocol.

### **Revision of the Manual for Medical Examination of Sexual Assault**

The manual for medical examination was revised, and new learnings from the past three years were incorporated. In particular, an annexure of data from the implementation of project in the three hospitals was included in the manual. It highlights some of the key findings relating to the large number of survivors reporting voluntarily to the hospital, the range of sexual acts that have been reported, the nature of health consequences etc. The data is useful in dispelling certain myths that health care providers carry. For instance, there is a widely prevalent myth that if the case is 'genuine' then injuries must be present. Data from CEHAT's intervention shows that more than half of survivors do not show genital injuries and 80 percent do not show physical injuries. Other additions to the manual include a pamphlet for health care providers that would help them to provide certain positive messages and address psychological consequences of the assault.

### **Capacity building on domestic violence**

The current team of Training Cell (2011-2012) comprises 68 health professionals which include 10 Doctors, 43 nurses, 2 matrons, and 6 Community Development Officers of hospitals, 2 Ayabais, 2 ward boys, 1 from electric department and 1 is occupational therapist, 1 ICTC counselor. The Training cell has been in existence since the past 6 years and a growing number of Health care providers associating themselves with it. The core groups have been conducting training in their respective hospitals, 1 training on domestic and sexual violence was conducted for the nurses in Bandra Bhabha where nurses were oriented to their role in responding to women facing violence. A similar training was also conducted at Oshiwara maternity home for the nurses. In Cooper hospital, a screening of the film on Dilaasa 'At the Crossroads' was organized by the core group.

## IV. INTERVENTION AND SERVICE PROVISION

### Crisis intervention services for survivors of sexual assault

We responded to 29 new cases in the reporting period, of which more than half were children. Crisis intervention services including psychological support to the client and her parents, safety assessment, interfacing with the police, etc have been provided to all clients. We have also continued to assist doctors in conducting the examination and provide support to survivors. Particularly, during this period, we have started receiving more number of FSL reports and doctors have been provided inputs in drafting final opinions. We have also secured conviction in one case that we received in October last year. In this case we were able to provide the survivor whatever support she required in order to pursue the case, including helping her move to another locality due to threats from the abuser. We prepared her to depose in the court and also dialogued with the PP regarding her case. We also worked with the doctor to ensure that he was able to testify and explain the medical evidence properly in her case. All of these factors helped in securing conviction.

One of the challenges to sexual assault has been that women do not follow up. After examination and treatment at the hospital level, most survivors are unable to come for follow up counselling. This is especially true when it comes to parents of sexually abused children. Often this has to do with their economic conditions. Some cannot afford the cost of travel. Coming for counselling also means that they would have to accompany the child; this would therefore mean loss of daily wages. Parents are not extremely comfortable with home visits as they fear that neighbours who may be unaware of the incident would enquire as to why the hospital people came to their residence. This often restricts our communication to telephone communication. Information is provided to parents about ways of dealing and comforting the abused child, the fact that she may have certain physical symptoms such as pain in urination, defecation and how to manage those, feelings of anxiety, sleeplessness, fear of being left alone, remarks from peers or community and how to enable the child to overcome them. However the recently declared compensation scheme for survivors of rape has enabled at least a few survivors to follow up with us. One of the reasons is that the economic compensation can offer them concrete support to relocate to another place, seek medical help from other sources, and enroll in to skill building program. The scheme is only valid for rape survivors of 2011. We have filed 6 such claims and submitted them to the women and child department.

Specific challenges have been faced with police during this period, particularly with filing of cases. Police have refused to file FIR under section 376, have detained survivors for hours at the police station before filing an FIR, have insisted on multiple examinations and the like. Our interventionists have had to help the survivor negotiate these problems at every step. This callousness of the police is a cause of concern and we have letter stating the problems has been sent to the DCP to take

action. This requires some action from the higher authorities and points to the need to develop standard operating procedures for the police as well.

### **Standard Operating Procedures (SOP) for Sexual Assault Response at Hospitals**

At the 3 hospitals where the comprehensive health care response to sexual assault is being implemented by CEHAT, a need emerged for standard operating procedures to guide hospital administrators and examining doctors in managing care for survivors of sexual assault. In response to difficulties that survivors encountered at these hospitals, which sometimes resulted in examination/treatment being delayed or denied, draft guidelines were prepared by CEHAT. The guidelines encompass provisions related to treatment, admission, free care, informed consent, police intimation and so forth. These will aid providers to adequately address the needs of survivors as well as meet procedural requirements. Feedback received from doctors in the SAFE Kit trainings reiterated the need for such guidelines.

The Savitribai Phule Gender Resource Center (SPGRC), a BMC initiative is established to address violence against women. A draft SOP was prepared by the team and shared the Savitribai Phule Gender Resource Center to assess the feasibility of implementing these in all MCGM hospitals of Mumbai. A presentation on the SOP was made to the SPGRC who endorsed it. They approached the Additional Municipal Commissioner (AMC) for its implementation. The AMC (City) approved the SOP and it is ready for implementation. This SOP will hopefully bring in uniform protocol in responding to Sexual Assault cases in at least the Municipal Corporation hospitals.

### **Dilaasa, Crisis Intervention Department**

The Dilaasa department in Bandra Bhabha Hospital has successfully completed 11 years. In the year April 2011 to March 2012, 201 new cases were registered in the centre. The proportion of cases referred from the hospital has reduced and this points to the need for continued capacity building training in the hospitals so that health care providers refer women facing abuse to the centre. 352 follow ups and 68 legal consultations were provided as well. In Kurla Bhabha hospital, 74 new cases were registered, there were 49 follow ups and 15 legal consultations. The crisis centre also continues to counsel women, who have consumed poison and deny a suicide attempt, they maintain that this was accidental. However counsellors make efforts to strike a dialogue about the impact of such consumption on their health and try and make efforts so that such women in denial come back to seek support. A total of 96 such women were counselled but not registered. The Dilaasa crisis centre continues to receive students and visitors from the discipline of social work, psychology and also nursing schools. Students from SNTD and TISS have been posted as interns at the centre. The Bhakti Vedanta College of Nursing also organized a field visit for their students to the Dilaasa crisis centre, in order to provide them exposure to the issue of VAW as a public health issue. The centre also received other forms of recognition this year. It was featured by Futures Without Violence as a model for responding to DV through the health system, during the 16 days of activism in November 2011. It was also featured in the television program Satyameva Jayate where in the project

director spoke about the health consequences of domestic violence and the health system as a site for intervention.

### **Replication of Dilaasa in Shillong, Meghalaya**

CEHAT collaborated with the North east network (NEN) to undertake the setting up of a hospital based crisis centre in Shillong. The centre has started functioning and NEN has been provided a room designated for setting up the crisis centre at the civil hospital in Shillong and a clinical psychologist was deputed to provide the required services to women survivors of violence. CEHAT dialogued with the NEN to depute staff from both the hospital as well as NEN to participate in the national course on feminist counselling to respond to the issue of Violence against women. One member from NEN and 1 counsellor from Ganeshdas hospital participated in the 5 day intensive course on feminist counselling, which was aimed at building an understanding on the issue of violence against women and understanding concepts linked to violence such as patriarchy , gender and others and finally actual hands on counselling sessions. Following this, two more trainings were held on counselling women facing violence, for a group of 20 clinical psychologists and social workers from all over Shillong. These were three day trainings that addressed concepts related to gender and violence as well as built skills for responding to survivors of domestic and sexual abuse through use of methods such as case discussions and role plays.

## DOCUMENTATION AND PUBLICATION (CEHAT)

The main focus in the last years was on editing fields in the SLIM Library software in order to add missing or incomplete data. The unit has along started bar coding the resources in the unit. The documentary section was editing and a short abstract of the documentaries and other documentary details were added to the section. In the reference and e-document sections links are given to the soft copies either on the web or in-house resources. This year Stock taking of the library was done with a detailed documentation of the process involved. We have also done a documentation of the SLIM data entry module. The main focus this year was in promotion of the resources and the website.

Promoting the Library and Documentation Unit Collection : This year we have put in efforts to promote the collection of the Library and Documentation that includes Online catalogue, research studies/resources available on CEHAT website to others organizations, individuals, students, institutes and academics apart from the old contacts through e-bulletin, group mails to target audience and other web-based tools.

The research area webpage was revamped so that the user can access the resources at one glance. If a user is looking for material on specific Research area it is easier to get all research project listed under that area with links to all the publications i.e. reports, paper/articles and resources material developed under that research area. <http://www.cehat.org/go/ResearchAreas/HealthServicesandFinancing>. A webpage on Domestic Violence (<http://www.cehat.org/go/DomesticViolence/Home> ) was developed which gives details about the work done by CEHAT in this area and links to various resources.

E-bulletin: We have put together two e-bulletin one on Domestic violence (<http://www.cehat.org/go/uploads/Library/ebulletinAugOct10.pdf>) and Health budget. The domestic violence e-bulletin is published and circulated to target audience and the health budget bulletin is ready for dissemination.

Literature Lists: Literature lists on Health Economic and Financing, Research Methodology and Public private partnership were put together and circulated to the internal staff which are now available in the unit.

## Publications

### Reports

1. Kurian, Oommen C.; Wagle, Suchitra and Raymus, Prashant. Mapping the flow of user fees in a public hospital. Mumbai: CEHAT, 82 p., 2011 [ISBN : 978-81-89042-58-5]
2. Contractor, S., Venkatachalam D, Keni Y, Mukadam R. Responding to sexual assault: A study of practices of health professionals in a public hospital. Mumbai: CEHAT and New Delhi: SAMA, 58 p., 2011 [ISBN: 978-81-89042-57-8]
3. Manual for medical examination of sexual assault. Revised edition. Mumbai: CEHAT, x,64 p., 2012 [ISBN: 978-81-89042-59-2]
4. Pradhan, Anagha and Shaikh, Tayyaba. Living on the Margins: Prawn Harvesters from Little Rann of Kutch (An Exploratory Study of Health Status). Gujarat: Anandi and Mumbai: CEHAT, 114 p., 2011 [ISBN: 978-81-89042-56-1].

### Articles

1. Kurian, Oommen C. "Charitable Hospitals: Charity at Market Rate" *Economic and Political Weekly*, 47(39) September 29, 2012, pp. 23-25
2. Deosthali, Padma and Rege, Sangeeta. "Violence faced by women health workers" In *Sexual harassment at workplace* edited by Deepti Deshpande and Nikhil Bhagwat. Nashik: Home Science Faculty of Gokhale Education Society's SMRK-BK-AK-Mahila Mahavidyalaya, 2012, pp. 104-112.
3. Bhate-Deosthali, Padma; T K Sundari Ravindran and Vindhya, U. "Addressing domestic violence within healthcare settings: The Dilaasa model" *Economic and Political Weekly*, 47(17) April 21 - April 27, 2012, pp. 66-75
4. Contractor, Sana. "Abortion and sex selection: Contentious issues in the campaign against sex selection" *The Urban World*, Special issue on sex selection and PCPNDT act. 4(3), July-Sep 2011, pp. 13-17
5. Contractor, Sana. "Reflections on the high court's dismissal of the 'TISS rape case'" *Indian Journal of Medical Ethics*, VII(4), Oct-Dec 2011, pp. 246-247
6. Rege, Sangeeta. "Medico-legal cases across various hospitals - A review & understanding of procedures" *Medico-Legal Update*, 11(2), 2011, pp. 67-69

### Poster Presentations

1. Contractor, Sana and V. Deepa "Interrogating the Health Sector Response to Sexual Assault: Findings from a Tertiary Care Hospital in India" Presented at the SVRI Forum 2011, October 11-13, Cape Town, South Africa.

### IEC Material

1. Dilaasa Calendar 2012: Looking Beyond Symptoms

Press coverage: 2011

- [http://www.dnaindia.com/mumbai/report\\_treatment-for-poor-not-free-study\\_1639386](http://www.dnaindia.com/mumbai/report_treatment-for-poor-not-free-study_1639386)
- <http://www.moneylife.in/article/needy-patients-get-nothing-while-charity-funds-earn-interest/23333.html>
- <http://www.moneylife.in/article/user-fee-keeps-poor-away-from-using-public-healthcare-facilities/21673.html>
- <http://www.hindu.com/2011/04/13/stories/2011041363640900.htm>
- <http://epaper.lokmat.com/newsview.aspx?eddate=04/03/2012&pageno=2&edition=41&prntid=2674&bxid=25869308&pgno=2>
- [http://articles.timesofindia.indiatimes.com/2012-04-01/mumbai/31270138\\_1\\_counsel-victims-sexual-assault-doctors](http://articles.timesofindia.indiatimes.com/2012-04-01/mumbai/31270138_1_counsel-victims-sexual-assault-doctors)
- <http://fpj.co.in/news/57398-City-doctors-being-trained-to-examine-victims-alt39objectivelyalt39.html>

## STAFF PROFILE

### List of CEHAT Staff as on 31<sup>st</sup> March 2012

Employee Name	Designation	Male/Femal
Anandi Dantas	Research Officer	Female
Anita Jain	Research Officer	Female
Anjali Kadam	Secretary	Female
Arvind Harekar	Secretary	Male
Deepmala Patel	Research Associate	Female
Dilip Jadhav	Office Assistant	Male
Dinali Hataskar	Admin Assistant	Female
Jasmine Kalha	Research Associate	Female
Margaret Rodrigues	Research Officer	Female
Meghna Jethava	Sr. Research Associate	Female
Oommen C. Kurian	Research Officer	Male
Prachi Avalaskar	Sr. Research Associate	Female
Prashant Raymus	Research Officer	Male
Pramila Naik	Jr. Administrative Officer	Female
Priyanka Shukla	Sr. Research Associate	Female
Rahul Sapkal	Sr. Research Associate	Male
Ramdas Marathe	Office Assistant	Male
Sana Contractor	Research Officer	Female
Sangeeta Rege	Sr. Research Officer	Female
Shobha Kamble	Office Assistant	Female
Sonal Sheth	Sr. Research Associate	Female
Suchitra Wagale	Sr. Research Associate	Female
Sudhakar Manjrekar	Office Assistant	Male
Sushma Patil	Jr. Account Officer	Female
Tayyaba Khatoon	Research Officer	Female
Ujwala Kadrekar	Sr. Research Officer	Female
Vijay Sawant	Secretary	Male
Yavnika Tanwar	Sr. Research Associate	Female
Zamrooda Khanday	Sr. Research Officer	Female